North Carolina Department of Health and Human Services

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Consumer Name _____ Date of Birth_____

Consumer Medical Record #_____ Client SS #_____

I _____ hereby authorize
(Consumer or Personal Representative)
_____ to disclose specific health information
(Name of Provider)
from the records of the above named client to: _____
(Name of the County Department of Social Services/Address/Phone/Fax)
_____

_____

for the specific purpose(s): of enabling the identified agencies to evaluate my possible substance abuse or dependence diagnosis so that I can obtain appropriate treatment and to continue to evaluate the safety of my children

Specific information to be disclosed: (consumer needs to initial each category that applies)

_____ my name and other personal identifying information
_____ initial evaluation
_____ date of admission
_____ assessment results
_____ summary of treatment plan
_____ progress and compliance with treatment
_____ attendance
_____ date of discharge and discharge status
_____ discharge plan

I understand that this authorization will expire on the following date, event or condition: Upon the closing of the protective services case by DSS or one year from the date this consent is signed (whichever comes first).

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

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NOTE: This Authorization was revoked on _____ _____

(Date) *(Signature of Staff)*

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Consumer)

signed by_____ on _____
(*Enter Name of Person Who Signed Authorization)* *(Enter Date of Signature)*

be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)

rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Consumer)	*(Date)*	*(Signature of Witness)*	*(Date)*

_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by _____
(Name of Consumer or Personal Representative)

on _____. The consumer or his/her personal representative has been informed that any action
(Date)

taken on this authorization prior to the rescinded date is legal and binding.

_____	_____	_____	_____
(Signature of Staff)	*(Date)*	*(Signature of Witness)*	*(Date)*